SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

DALE MEDICAL CENTER
100 HOSPITAL AVENUE
OZARK, AL 36360

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Debbie Mathews ☐ Agent ☐ Addressee

B. Received by (Printed Name) Debbie Mathews

C. Date of Delivery 6/14/05

D. Is delivery address different from item 1? ☐ Yes
If YES, enter delivery address below: ☐ No

1:05cv540-W
SRW

3. Service Type
☒ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? *(Extra Fee)* ☐ Yes

2. Article Number *(Transfer from service label)* 7002 2030 0000 7864 6492

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540